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Correspondence

Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors

TO THE EDITOR, *Genitourinary Medicine*

Genital herpes diagnosed by cervical cytology

Sir,

The cervix is commonly affected by first attacks of genital herpes, but much less often by recurrences.[1] The definitive method of diagnosing genital herpes is by growing the virus in tissue culture.[2] Cells obtained from the cervix by exfoliative cytology, however, may show changes characteristic of herpes simplex virus (HSV) infection. These features consist of the homogenisation of nuclear contents, margination of chromatin leading to a "ground glass" appearance, multinucleation leading to the formation of giant cells, and the presence of intranuclear eosinophilic inclusions.[3] HSV infection is only rarely detected on cervical cytology. A study in Atlanta, United States of America, showed features of HSV in only 0·16% of 40 000 smears,[3] and a similar result was obtained in an analysis of over 57 000 cervical smears in Finland.[4]

We carried out this study to assess the clinical characteristics of patients in whom HSV was detected on routine cervical cytology. The case notes of all women attending the department of genitourinary medicine at the Middlesex Hospital during a two year period whose cervical smears showed changes characteristic of HSV were analysed retrospectively. We noted any history of genital herpes and the presence of herpetic lesions and of any coexisting sexually transmitted disease (STD). Differences were compared using Fisher's exact test.

We found 30 women with genital herpes. In 21 it was suspected at the initial visit, material for viral culture was obtained from the cervices of 20 of them, and all cultures gave positive results. In the remaining nine women genital herpes was not suspected, and viral cultures had not been performed at the initial clinic visit. Material for viral cultures was obtained two weeks later from five, and all gave negative results. Sixteen of the 30 women had one or more genital infection in addition to HSV. The cervices appeared abnormal in 19 (63%) of the women, although the appearances in women in whom herpes was suspected were similar to the appearances in women in whom it was not suspected (table).

Table *Appearance of cervices of 30 women infected with herpes simplex virus (HSV) (figures are numbers (percentages) of women with given abnormality)*

Abnormality	*HSV suspected (n = 21)*	*HSV not suspected (n = 9)*
Cervicitis	10 (48)	5 (56)
Ulceration	3 (14)	0
Necrosis	1 (5)	0
Total	14 (67)	5 (56)
Infected with other organisms*	11 (53)	5 (56)

*These comprised: *Trichomonas vaginalis*, *Neisseria gonorrhoeae*, human papillomavirus, *Chlamydia trachomatis*, *Candida albicans*, and *Gardnerella vaginalis*. Several patients had multiple infections.
Note: No significant differences were seen between the two groups.

In cases where genital herpes is suspected the detection of changes suggestive of herpes on cervical cytology does not pose a problem. When genital herpes is not suspected but cytology results suggest HSV infection, however, the clinician is faced with several problems, including what to tell the patient and how to confirm the diagnosis. We suggest that the patient be recalled as soon as possible and told that there are nonspecific changes on her cervical smear. A careful history should be taken for symptoms suggestive of previous episodes of genital herpes, and material for viral cultures taken from the cervix and any other suspect sites. Screening for other STDs should be performed if this had not been carried out at the initial clinic visit. Unfortunately, as the results of cervical cytology are not usually available for several weeks, confirmation by a positive viral culture result will seldom be achieved. Conversely, a negative cervical culture result will not exclude genital herpes.

If a woman gives a history indicative of genital herpes, she should be asked to return immediately for repeat viral cultures if she experiences further symptoms. In the absence of such a history it is pointless to repeat viral cultures at random as these are unlikely to be positive. Nor could the doctor, if he told her his provisional diagnosis, counsel the woman how to prevent transmission to her sexual partner effectively. Regular and indefinite use of condoms would not be acceptable to most women, especially when the diagnosis is not certain.

Yours faithfully,

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TO THE EDITOR, *Genitourinary Medicine*

Topical anthelmintic treatment of recurrent genitourinary enterobiasis

Sir,

The vagina, uterus, fallopian tubes, peritoneum, and surfaces of the ovaries are common sites of extraintestinal enterobiasis, which rarely affects the ovarian and renal parenchyma.[1,2] Chronic enterobiasis of the urinary tract with related clinical manifestations is rare.[3] We encountered an interesting case of chronic genitourinary oxyuriasis that lasted for more than 18 months. A married, fertile, Moslem woman aged 20 attended complaining of burning on micturition and crawling sensations in her vagina and urethra. Examination of her catheteric urine showed profuse pyuria, but no casts or erythrocytes. Ova and larvae of *Enterobius vermicularis* were, however, repeatedly found in her urine and vaginal discharge. She had received various systemic and oral regimens of antimicrobials and anthelmin-